

Health, Welfare
Public
Service

FILED OCT 15 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 167

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington Township</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Pleasant Hope</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital 3</u> | | Length of stay in lb <u>7 years</u> | d. STREET ADDRESS (If outside, give location) <u>Rt</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES - PRITCHARD - CLEM</u> | | | 4. DATE OF DEATH Month Day Year <u>Oct 2, 1957</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>April 4, 1905</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>52</u> Months <u>5</u> Days <u>30</u> Hours <u>-</u> Min. <u>-</u> |
| 11. BIRTHPLACE (City and state or country) <u>Des Moines Iowa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Edwin Clem</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mabel Pritchard</u> | 14. NAME OF HUSBAND OR WIFE <u>unknown</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>702-07-7429</u> | 17. INFORMANT <u>Records State Hospital 3 Nevada Mo</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Probably Rheumatic</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dementia Precox</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>several years</u> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>415X</u> | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____ | | | |
| 20d. INJURY OCCURRED - WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>remained Remains</u> | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
| 21. I attended the deceased from <u>Sept 29, 1957</u> to <u>Oct 3, 57</u> and last saw her alive on <u>October 2, 1957</u> Death occurred at <u>5 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Paul L. Barone, M.D.</u> | | 22b. ADDRESS <u>State Hospital 3 Nevada Mo</u> | 22c. DATE SIGNED <u>Oct 2/57</u> |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Oct. 2, -57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Welch Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Springfield Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Klingner Funeral Home</u> | | 25. DATE RECD. BY LOCAL REG. <u>10-9-1957</u> | 26. REGISTRAR'S SIGNATURE <u>Arma E. Ferruf</u> |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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OCT 15 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Percy F. Wilster*
Licensed Embalmer No. *4805*
P. O. Address *Nevada, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.